shall extend the class ceiling exception for subsequent 6-month periods upon making a determination that a need for the exception still exists and upon providing the CMS Regional Office with another advance written notification as stated above.

D. Effective October 1, 1985, FRVS shall be used to reimburse facilities for property. To prevent any facility from receiving lower reimbursement under FRVS than under the former method where depreciation plus interest costs were used to calculate payments, there shall be a transition period in which some facilities shall continue to be paid depreciation plus interest until such time as FRVS payments exceed depreciation and interest payments as specified in Section V.E.1.h. At that time, a facility shall begin reimbursement under the FRVS. Facilities entering the program after October 1, 1985 that had entered into an armslength (not between related parties) legally enforceable agreement for construction or purchase loans prior to October 1, 1985 shall be eligible for the hold harmless clause per Section V.E.l.h.

E. The prospectively determined individual nursing home's rate will be adjusted retroactively to the effective date of the affected rate under the following circumstances:

1. An error was made by AHCA in the calculation of the provider's rate.

2. A provider submits an amended cost report used to determine the rate in effect. An adjustment due to the submission of an amended cost report shall not be granted unless the amended cost report shall cause a change of 1 or more percent in the total reimbursement rate. The provider shall submit documentation supporting that the 1 percent requirement is satisfied. This documentation shall include a rate calculation using the same methodology and in a similar format as used by the Agency in calculating rates. The amended cost report shall be filed by the filing date of the subsequent cost report or the date of the first field audit

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exit conference for the period being amended or the date a desk audit letter is received by the provider for the period being amended, whichever is earlier.

3. Further desk or on-site audits of cost reports disclose a change in allowable costs in those reports.

4. The section shall not apply to the case-mix adjustment calculated in Section V.G. of this plan.

F. The Medicaid program shall pay a single level of payment rate for all levels of nursing care. This single per diem shall be based upon each provider's allowable Medicaid costs divided by the Medicaid patient days from the most recent cost report subject to the rate setting methodology in Section V. of this plan.

G. Reimbursement of operating and patient care costs are subject to class ceilings. Property costs are subject to statewide ceilings, which shall be the ceilings computed at July 1, 1985, for facilities being reimbursed under Section III.G.3.-5. of this plan. For facilities being reimbursed under FRVS, the cost per bed ceiling shall be per Section V.E.1.g. of this plan. Return on equity and use allowance are passed through and are not subject to a ceiling.

H. An incentive factor is available to providers whose operating per diems are under the class ceiling and who have provided quality of care resulting in standard ratings on the license issued by AHCA pursuant to the provisions of Rule 59A-4.128, F.A.C. Additional incentive is available for providers who have been granted superior quality of care licensure ratings. Beginning with the July 1, 1996, rate semester, incentive factor payments will no longer be made and a Medicaid Adjustment Rate shall be made pursuant to Section V.F. of this plan.

I. A low occupancy adjustment factor shall be applied to costs of certain providers.

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J. The following provisions apply to interim changes in component reimbursement rates, other than through the routine semi-annual rate setting process.

1. Requests for rate adjustments to account for increases in property-related costs due to capital additions, expansions, replacements, or repairs, or for allowable lease cost increases shall not be considered in the interim between cost report submissions, except for the addition of new beds or if the cost of the specified expansion, addition, replacement, allowable lease cost increase or repair would cause a change of 1 percent or more in the provider's total per diem reimbursement rate. For facilities being reimbursed under FRVS, property-related costs shall not be considered in any interim rate request. Adjustments to FRVS rates for property-related costs shall be made only on January 1 and July 1 of each year per Section V.E.1.j.

2. Interim rate changes reflecting increased costs occurring as a result of patient care or operating changes shall be considered only if such changes were made to comply with existing State or Federal rules, laws, or standards, and if the change in cost to the provider is at least $5000 and would cause a change of 1 percent or more in the provider's current total per diem rate.

(a) If new State or Federal laws, rules, regulations, licensure and certification requirements, or new interpretations of existing laws, rules, regulations, or licensure and certification requirements require providers to make changes that result in increased or decreased patient care, operating, or capital costs, requests for component interim rates shall be considered for each provider based on the budget submitted by the provider. All providers' budgets submitted shall be reviewed by the Agency and shall be the basis for establishing reasonable cost parameters.

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(b) In cases where new State or Federal requirements are imposed that affect all providers, appropriate adjustments shall be made to the class ceilings to account for changes in costs caused by the new requirements effective as of the date of the new requirements or implementation of the new requirements, whichever is later.

3. Interim rate adjustments shall be granted to reflect increases in the cost of general or professional liability insurance for nursing homes if the change in cost to the provider is at least $5000 and would cause a change of 1 percent or more in the provider's current total per diem.

4. Interim rate requests resulting from 1., and 2. above must be submitted within 60 days after the costs are incurred, and shall be accompanied by a 12-month budget that reflects changes in services and costs. For providers being reimbursed under FRVS, interim rate adjustments due to capital additions or improvements shall be made per Section V.E.1.j. An interim reimbursement rate, if approved, shall be established for estimated additional costs retroactive to the time of the change in services or the time the costs are incurred, but not to exceed 60 days before the date AHCA receives the interim rate request. The interim per diem rate shall reflect only the estimated additional costs, and the total reimbursement rate paid to the provider shall be the sum of the previously established prospective rates plus the interim rate. A discontinued service would offset the appropriate components of the prospective per diem rates currently in effect for the provider. Upon receipt of a valid interim rate received after August 31, 1984, the AHCA Office of Medicaid shall determine whether additional information is needed from the provider and request such information within 30 days. Upon receipt of the complete, legible additional information as requested, the AHCA Office of

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Medicaid shall approve or disapprove the interim rate request within 60 days. If the AHCA office of Medicaid does not make such determination within the 60 days, the interim rate request shall be deemed approved.

5. Interim Rate Settlement. Overpayment as a result of the difference between the approved budgeted interim rate and actual costs of the budgeted item shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual costs shall be paid to the provider.

6. Interim rates shall not be granted for fiscal periods that have ended.

Interim rates for the additional staffing requirements effective January 1, 2002 and 2003 shall not be granted, as providers incurring additional costs to meet the new minimum staffing standards will receive a "gross-up adjustment" as described in section V.B 4 . For the costs incurred from the additional CNA staff hired during November 2002 and December 2002 to meet the January 1, 2003 staffing requirements prior to January 1, 2003, interim rates will be considered in accordance with section IV.J 2 and 4 above for that period only, and removed January 1, 2003 due to the implementation of the gross-up methodology described in V.B.4.

7. For costs incurred prior to January 1, 2002 by providers who have submitted the supplemental schedule, the following methodology will be used:

November 2001 = 50% of the additional costs as computed in section V.B4 on a daily per diem basis times the number of days in November that costs were incurred to meet the January 1, 2002 staffing requirements shall be reimbursed;

December 2001 = 75% of the additional costs as computed in section V.B4 on a daily per diem basis times the number of days in December

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that costs were incurred to meet the January 1, 2002 staffing requirements shall be reimbursed.

No costs will be recognized by providers incurring additional costs to meet the new minimum staffing standards prior to November 1, 2001.

K. The following applies to rate periods prior to July 1, 1985: In the event that a provider receives a new licensure rating making him eligible or ineligible for any amount of incentive payments, his prospective reimbursement rate shall be changed to reflect his new licensure rating and shall be effective beginning on the first day of the month after the month in which the new licensure rating became effective. For rates effective on or after July 1, 1985, the incentive payments based on licensure ratings shall be calculated according to the provisions of Section V.D. below.

L. Effective April 1, 1999 there will be a case-mix adjustment, which will be paid as an add-on to the patient care component of the provider's total reimbursement rate. The amount of the case-mix adjustment will be calculated pursuant to Section V.G. of this plan. Effective January 1, 2002, the case-mix adjustment will be eliminated

M. Effective January 1, 2002, providers will be required to complete a supplemental schedule from the Medicaid cost report filed to be used in the January 1, 2002 rate setting. The information reported on the supplemental schedule will be used to rebase the patient care component of the Medicaid per diem rate and to calculate a "gross-up adjustment" to facility rates at January 1, 2002 for the increased staffing requirements.

N. Aggregate Test Comparing Medicaid to Medicare 42 CFR 447.253(b)(2) (1994) provides that states must assure the The Centers for Medicare and Medicaid Services that "The Medicaid agency's estimated average proposed payment rate...pay no more in the aggregate for...long-term care facility services than the amount that...would be paid for the services under the Medicare principles of reimbursement." At any rate-setting

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period, if the aggregate reimbursement to be paid is higher than would be paid under Medicare reimbursement principles, the following steps shall be taken for that rate semester, in order, as necessary to meet the aggregate test:

1. The increase in property reimbursement due to indexing for FRVS shall be reduced until the upper limit test is met for that rate semester. The amount of the property reimbursement rate paid under FRVS shall be reduced, but not below the initial per diem the provider received under FRVS. This per diem is inclusive of all components of FRVS, including property, return on equity, taxes and insurance.
2. Any incentive payments or other payments that exceed the projected cost rate shall be reduced on a pro rata basis until Medicaid aggregate payments are equal to or less than the amount that would be paid for services under the Medicare reimbursement principles.
3. If provisions 1 and 2 are implemented in order to meet the upper limit test, for a period of 1 year, this plan shall be reanalyzed and formally amended to conform to the necessary program cost limits.

O. Payments made under this plan are subject to retroactive adjustment if approval of this plan or any part of this plan is not received from the federal Centers for Medicare and Medicaid Services (CMS). The retroactive adjustments made shall reflect only the federal financial participation portions of payments due to elements of this plan not authorized by CMS.

V. Method

This section defines the methodologies to be used by the Florida Medicaid program in establishing reimbursement ceilings and individual nursing home reimbursement rates.

A. Ceilings.

1. Ceilings shall be determined prospectively and shall be effective semi-annually on January 1 and July 1. The most current acceptable cost reports postmarked or accepted by a common carrier by October 31 or April 30 and received by November 15 or May 15, respectively, of each year and the provider's most recent reimbursement rates shall be used to establish the operating and patient care ceilings. . The first cost report submissions for all newly constructed facilities shall be used to establish the property cost ceiling. The first cost report year-end for these newly constructed facilities must be after October 1, 1977. In addition, all facilities with year-ends prior to that of the one-hundredth facility in an array from most current to least current year end shall not be considered in setting the property cost ceiling. The ceiling for property computed here shall be used for all facilities not yet being reimbursed under FRVS. The ceiling computed at July 1, 1985 shall be used beginning with July 1, 1985 rates, and all subsequent rates for facilities until they begin receiving reimbursement under FRVS. For those facilities being reimbursed under FRVS, the cost per bed ceiling per Section V.E.1.g. of this plan shall be used.

2. For the purpose of establishing reimbursement limits for operating and patient care costs, four classes based on geographic location and facility size were developed. These classes are as follows:

   a. Size 1-100 beds - Northern Florida Counties

   b. Size 101-500 beds- Northern Florida Counties

   c. Size 1-100 beds - Southern Florida Counties

   d. Size 101-500 beds- Southern Florida Counties

   For purposes of defining the four reimbursement classes, the "Southern Florida Counties" shall be comprised of:

Broward	Hardee-	Monroe
Charlotte	Hendry	Okeechobee
Collier	Highlands	Palm Beach
Dade	Indian River	Polk
Desoto	Lee	St. Lucie
Glades	Martin	Sarasota

All remaining Florida Counties shall be "Northern Florida Counties."

3. As of July 1, 1994, two additional reimbursement classes shall be defined as follows:

   a. Size 1-100 beds - Central Florida Counties

   b. Size 101-500 beds - Central Florida Counties

   The "Central Florida Counties: shall be comprised of:

Brevard	Manatee	Pinellas
Hardee	Orange	Polk
Highlands	Osceola	Seminole
Hillsborough	Pasco	

   The "Northern Florida Counties" and "Southern Florida Counties" shall be comprised of the counties enumerated in Section V.A.2. less the "Central Florida Counties" as defined above.

4. Nursing homes participating in the Medicaid program as of July 1, 1994, and located in Hardee, Highlands, or Polk County, shall be "grand-fathered in," and shall be considered as members of the "Southern Florida Counties" class, until such time that the "Central Florida Counties" class reimbursement ceilings for the operating cost and patient care cost components equal or exceed the corresponding July 1, 1994, "Southern Florida Counties" class ceilings. The "grandfathered-in" provision shall be applied separately for the operating cost and patient care cost components in each of the two facility size classes. That is, nursing facilities of a given size in Hardee, Highlands, and Polk counties shall be

considered as members of the applicable "Southern Florida Counties" size class in the operating cost component until such time as the "Central Florida Counties" operating cost component ceiling equals or exceeds the July 1, 1994, "Southern Florida Counties" operating cost component ceiling for that class. Nursing facilities of a given size in Hardee, Highlands, and Polk counties shall be considered as members of the applicable "Southern Florida Counties" size class in the patient care cost component until such time as the "Central Florida Counties" patient care cost component ceiling equals or exceeds the July 1, 1994, "Southern Florida Counties" patient care cost component ceiling.

B. Setting prospective reimbursement per diems and ceilings. In determining the class ceilings, all calculations for Sections V.B. 1. - V. B. 18. shall be made using the four class, and "Northern Florida Counties" and "Southern Florida Counties" definitions of sections V.A. 2. above. All calculations for Sections V.B.19. - V.B.21 shall be made using the six class and "Central Florida Counties" definition of Section V.A.3. above. The Agency shall:

1. Review and adjust each provider's cost report referred to in A.l. to reflect the result of desk or on-site audits, if available.

2. Reduce a provider's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30 (1997)

3. Determine total allowable Medicaid cost.

4. Determine allowable Medicaid property costs, operating costs, patient care costs, and return on equity or use allowance. Patient care costs include those costs directly attributable to nursing services, dietary costs, activity costs, social services costs, and all medically ordered therapies. All other costs, exclusive of property cost and return on equity or use allowance costs, are considered

operating costs. For providers receiving FRVS payments, the return on equity cost or use allowance cost shall be reduced by the amount attributable to property assets, and the FRVS rate shall reflect a return on equity for property assets as per Section III.J. and K.

a. Effective January 1, 2002, there will be direct care and indirect care subcomponents of the patient care component of the per diem rate. These two subcomponents together shall equal the patient care component of the per diem rate. Providers will be required to complete a supplemental schedule for the Medicaid cost report to be used in the January 1, 2002 rate setting. The supplemental schedule shall contain the direct subcomponent of the patient care costs. Providers who do not submit a supplemental schedule shall have all patient care costs allocated into direct care and indirect care subcomponents based on a 65% and 35% split, respectively. Providers who do not submit the supplemental schedule will be excluded from the calculation of patient care ceilings.

Providers who do not submit the supplementary schedule will not have their costs "grossed-up," as detailed in b. below, if their staffing ratios do not meet the mandated minimum staffing standards for January 1, 2002. For providers filing a late supplemental schedule, there will be no retroactive adjustment to direct care or indirect care allocation or to the "gross-up." The late-filed supplemental schedule will not be used until the following prospective January 1 and July 1 rate semesters.

b. For the January 1, 2002 rate semester, each prospective provider's direct care subcomponent will be adjusted for the additional costs incurred by the provider to comply with the minimum staffing requirements for nursing (registered nurses

and licensed practical nurses) and certified nursing assistants (CNA's). This adjustment will be based on the information provided by each provider in the supplemental schedule filed with the cost report used to establish the January 1, 2002 Medicaid per diem rate.

The total reported productive hours for registered nurses (RN), licensed practical nurses (LPN), and CNA's will each be divided by the number of total patient days reported. Total reported productive hours include hours for employees of the facility and hours for leased staff. The result will represent the hours per patient day for each level of nursing service. The productive hours per patient day for RN's and LPN's will be combined for total productive nursing hours per patient day. Gross-up factors will be calculated for nursing hours and CNA hours by dividing the productive nursing hours per patient day into 1.0 and dividing the productive CNA hours per patient day into 2.3. Facility direct care subcomponent nursing costs will be multiplied by the nursing gross-up factor if the factor is greater than 1.0, and by 1.0 if the factor is less than or equal to 1.0. Facility direct care CNA cost will be multiplied by the CNA gross-up factor if the factor is greater than 1.0, and by 1.0 if the factor is less than or equal to 1.0. These adjusted nursing and CNA costs will be added together to obtain the adjusted direct care costs.

The adjusted direct care costs will be used for the purpose of computing ceilings and the prospective per diem rate.

c. Beginning with the January 1, 2003 rate semester, each prospective provider's direct care subcomponent for nursing (registered nurses and licensed practical nurses) will be adjusted based on the information provided by each provider in the supplemental schedule filed with the cost report used to establish

the January 1, 2003 Medicaid per diem rate. The total reported productive hours for registered nurses (RN) and licensed practical nurses (LPN) will be divided by the number of total patient days reported. Total reported productive hours include hours for employees of the facility and hours for leased staff. The result will represent the hours per patient day for nursing service. The productive hours per patient day for RN's and LPN's will be combined for total productive nursing hours per patient day. Gross-up factors will be calculated for nursing hours by dividing the greater of nursing hours per patient day or the weighted minimum requirement for the cost reporting period (weighted by days) into 1.0. The nursing weighted minimum requirement shall be used for cost reports ending May 31, 2002 or later. The nursing weighted minimum requirement shall be weighted by days using .6 hours per patient day prior to January 1, 2002 and 1.0 hours per patient day after Janaury 1, 2002, using the time period defined in the cost report used to set the respective rate. Facility direct care nursing costs will be multiplied by the nursing gross-up factor if the factor is greater than 1.0, and by 1.0 if the factor is less than or equal to 1.0. The gross-up factor will apply for all per diem rates using cost reports that include any costs incurred prior to January 1, 2002. All rates based upon cost reports that begin on or after January 1, 2002 will receive a gross-up factor of 1.0, as such cost reports will reflect full costs at the nursing staffing requirements post January 1, 2002.

Beginning with the January 1, 2003 rate semester, each prospective provider's direct care subcomponent will be adjusted for the incremental costs incurred by the provider to comply with the minimum staffing requirements for certified nursing assistants (CNAs). This adjustment will be based on the information provided by each provider in the supplemental schedule filed with the cost report

used to establish the January 1, 2003 Medicaid per diem rate. The total reported productive hours for CNAs will be divided by the number of total patient days reported. Total reported productive hours include hours for employees of the facility and hours for leased staff. The result will represent the hours per patient day for CNA nursing service. Gross-up factors will be calculated for CNA hours by dividing the greater of hours per patient day or the weighted minimum requirement for the cost reporting period (weighted by month) into 2.6. The CNA weighted minimum requirement shall be used for cost reports ending May 31, 2002 or later. The nursing CNA weighted minimum requirement shall be weighted by days using 1.7 hours per patient day prior to January 1, 2002 and 2.3 hours per patient day after Janaury 1, 2002, using the time period defined in the cost report used to set the respective rate. Facility direct care CNA costs will be multiplied by the CNA gross-up factor if the factor is greater than 1.0, and by 1.0 if the factor is less than or equal to 1.0.

The adjusted direct care costs will be used for the purpose of computing ceilings and the prospective per diem rate.

5. Calculate per diems for each of these four cost components by dividing the components' costs by the total number of Medicaid patient days from the latest cost report. For providers receiving FRVS cost reimbursement, substitute the appropriate FRVS per diem as per Section V.E. of this plan.

6. Adjust a facility's operating and patient care per diem costs that resulted from Step B.5 for the effects of inflation by multiplying both of these per diem costs by the fraction: Florida Nursing Home Cost Inflation Index at midpoint of prospective rate period, divided by the Florida Nursing Home Cost Inflation Index at midpoint of provider's cost report period. The calculation of the Florida

Nursing Home Cost Inflation Index is displayed in Appendix A. Only providers being paid a prospective rate under section V.B.6. shall be eligible for the Medicaid Adjustment Rate (MAR) except for those providers defined in section I.B. of the Plan.

7. Adjust, for those facilities not being paid under FRVS, all four components of the per diem for low occupancy per a. through g. below. For those facilities being paid under FRVS, adjust the operating cost component, the patient care cost component, and the return on equity or use allowance cost component, but do not adjust the property component for low occupancy.

   a. Calculate the percentage of occupancy for each facility.

   b. Calculate the mean and the standard deviation of the distribution of occupancy levels obtained in 7.a.

   c. Calculate the percentage of Medicaid days to total days for each facility ("percent Medicaid").

   d. Calculate the mean and the standard deviation of the distribution of percent Medicaid obtained in 7.c.

   e. Calculate the adjusted per diem components by multiplying each of the per diem components by the fraction: Individual facility occupancy level, divided by the statewide mean occupancy level less one standard deviation of occupancy levels from Step B.7.b.

   f. The adjustment described in e. above shall not apply to:

      1) Facilities with occupancy levels that exceed the statewide mean occupancy level less one standard deviation;

      2) Facilities with only one cost report filed.

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